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In the Supreme Court of the United States

JOSÉ MONTEMAYOR, COMMISSIONER, TEXAS DEPARTMENT OF INSURANCE, ET AL., PETITIONERS

v.

CORPORATE HEALTH INSURANCE, INC., ET AL.

RUSH PRUDENTIAL HMO, INC., PETITIONER

v.

DEBRA C. MORAN, ET AL.

ON PETITIONS FOR WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE FIFTH AND SEVENTH CIRCUITS

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

1. Whether state laws providing for external independent review of managed care organizations' medical necessity decisions are preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*

2. Whether state laws providing for external independent review of managed care organizations' medical necessity decisions are preempted by the Federal Employees Health Benefits Act of 1959, 5 U.S.C. 8901 *et seq.* (No. 00-665 only.)

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This brief is submitted in response to the Court's invitations to the Solicitor General to express the views of the United States.

STATEMENT

1. a. *Montemayor.* The *Montemayor* case involves a challenge to a 1997 law (Senate Bill 386), enacted by the State of Texas as an amendment to its insurance code, which, among other things, creates an independent review organization (IRO) process for certain decisions by a health maintenance organization (HMO). 00-665 Pet. App. B2-B3, E1-E7. That process provides for binding external review by an independent physician, at the request of an enrollee, Tex. Ins. Code Ann. § 21.58A (West Supp. 2001), of decisions made "by a

health maintenance organization or a utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate." *Id.* § 20A.12A(a)(1).

b. Shortly after the passage of the law, Corporate Health Insurance, Inc., and a number of other HMOs and insurers brought suit in the United States District Court for the Southern District of Texas against the Texas insurance commissioner and the state attorney general, arguing that the Texas law is preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, and the Federal Employees Health Benefits Act of 1959 (FEHBA), 5 U.S.C. 8901 *et seq.* The district court held that the provisions of the Act that impose liability on HMOs for providing substandard medical care are not preempted by ERISA or FEHBA. 00-665 Pet. App. B51-B52, B80. The court held that certain other provisions of the Act are preempted by ERISA. *Id.* at B72-B75 (anti-indemnity and anti-retaliation provisions preempted). And, in the ruling pertinent to the principal question presented in these petitions, the court held that the Texas law's provisions for independent review of medical necessity decisions are also preempted by ERISA. *Id.* at B67, B70. See also *id.* at B15 (concluding that the Texas provisions for independent review are not saved as insurance regulation because, in the court's view, they were not limited to entities within the insurance industry). The court held that no provisions of the Act are preempted by FEHBA. *Id.* at B77-B80.

c. The Fifth Circuit affirmed in relevant part. The Secretary of Labor appeared as amicus curiae in the court of appeals, arguing, *inter alia*, that the external review provisions are not preempted by ERISA.

As an initial matter, the court of appeals agreed with the district court that the liability provisions of the state law are not preempted, but disagreed with the lower court's conclusion that ERISA preempts the anti-retaliation and anti-

indemnity provisions. 00-665 Pet. App. A7-A11. The court then addressed the validity of the independent review provisions in light of Section 514(a), 29 U.S.C. 1144(a), ERISA's express preemption provision. It concluded that the IRO provisions "relate to" ERISA plans within the meaning of Section 514(a), reasoning that those provisions "include determinations by managed care entities as to coverage, not just negligent decisions by a physician," and thus fall "squarely within the ambit of ERISA's preemptive reach." 00-665 Pet. App. A13.

Applying the factors articulated by this Court in *UNUM Life Insurance Co.* v. *Ward*, 526 U.S. 358 (1999), the court of appeals further determined that the IRO provisions "regulate[] insurance" within the meaning of ERISA's insurance saving clause in Section 514(b)(2)(A) of the Act, 29 U.S.C. 1144(b)(2)(A). 00-665 Pet. App. A13-A15. The court first concluded that the IRO provisions satisfy the common-sense test of insurance regulation because they apply only to entities acting as insurers, and, by mandating a contract term that includes certain procedural requirements, they go to the heart of the relationship between the insured and the insurer. *Id.* at A14-A15. "For the same reasons," the court held, "the provisions satisfy the second and third prongs of the McCarran-Ferguson [Act]" test of what constitutes an insurance regulation, see *UNUM*, 526 U.S. at 373-374, although they "probably do not meet the first factor of reallocating the risk between the insured and insurer." 00-665 Pet. App. A15.[1]

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[1] The court of appeals thus disagreed with the district court's conclusion that the state law failed to meet the third factor, which requires that a law be limited to the insurance industry, because it applied to managed care entities as well as more traditional insurers. 00-665 Pet. App. A14-A15. The court of appeals reasoned that the relevant inquiry is whether the law is limited in its application to entities (including HMOs) acting as insurers. *Id.* at A14. It found the Texas law to be so limited. *Ibid.*

The court's analysis did not stop there, however. Instead, it held that "even if the provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA." 00-665 Pet. App. A15. Based on its view that *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987), held that ERISA's judicial enforcement scheme in Section 502(a) of the Act, 29 U.S.C. 1132(a) (1994 & Supp. V 1999), "preempts not only directly conflicting remedial schemes, but also supplemental state law remedies," the court reasoned that "the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan." 00-665 Pet. App. A15. The court concluded that the "quasi-administrative procedure" in the IRO provisions for reviewing denials of benefits provides "an alternative mechanism" for obtaining the identical relief offered by Section 502(a), and as such conflicts with Section 502(a). *Id.* at A15-A16.

Additionally, the court concluded that the independent review provisions are preempted by FEHBA because they "specifically conflict with the administrative remedy provided by the Office of Personnel Management concerning benefits disputes." 00-665 Pet. App. A17.

d. On petition for rehearing, the panel rejected the State's argument that this Court's intervening decision in *Pegram* v. *Herdrich*, 530 U.S. 211, 237 (2000), which held that mixed medical-eligibility decisions made by an HMO through its physicians are not fiduciary decisions under ERISA, cast doubt on the court's conclusion that the external review provisions are preempted. The court stated that *Pegram* does not lead to the conclusion that "every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment." 00-665 Pet. App. D2-D3.

2. *Rush Prudential.* Section 4-10 of the Illinois Health Maintenance Organization Act, 215 Ill. Comp. Stat. Ann. 125/1-1 *et seq.* (West 1993 & Supp. 2001), requires an HMO to

submit to binding independent review whenever there is a disagreement between a patient's primary care physician and an HMO over whether a course of treatment is medically necessary. 00-1021 Pet. App. 6a. The *Rush Prudential* case arises from such a disagreement.

a. Respondent Debra C. Moran is a beneficiary under a medical benefit plan sponsored by her husband's employer and governed by ERISA. 00-1021 Pet. App. 3a. Respondent Rush Prudential HMO (Rush) provides "medically necessary" benefits under the plan. *Ibid.*

Moran first sought treatment in 1996 from her Rush-affiliated primary care physician, Dr. LaMarre, for pain, numbness, loss of function, and decreased mobility in her right shoulder. 00-1021 Pet. App. 3a. Moran then consulted at her own expense with Dr. Julia Terzis, an out-of-network surgeon. *Id.* at 3a-4a. Dr. Terzis recommended that Moran undergo a surgical microneurological procedure to correct her problem. *Id.* at 4a. Two Rush-affiliated thoracic surgeons confirmed Dr. Terzis's diagnosis, but recommended a standard and less complicated (and less expensive) surgical procedure. *Id.* at 4a, 5a. Moran, however, supported by Dr. LaMarre, unsuccessfully sought approval from Rush for the procedure recommended by Dr. Terzis. *Id.* at 5a.

b. In January 1998, Moran made a written demand on Rush to comply with the Illinois independent review provision. 00-1021 Pet. App. 6a. When Rush did not act on her request, Moran filed a suit in state court to require Rush to submit to binding independent review. *Id.* at 6a-7a. Rush removed the action to federal district court on the ground that the claim was completely preempted by ERISA, but the district court remanded. *Id.* at 6a-7a, 34a. In the meantime, Moran opted to undergo the surgery by Dr. Terzis in February 1998. *Id.* at 6a. She submitted the bill for $94,841.27 to Rush. *Ibid.*

c. On remand, the state court ordered Rush to submit to independent review. 00-1021 Pet. App. 7a, 36a. The inde-

pendent reviewing physician determined that surgery was medically necessary, and he reported that he would have used a procedure similar to that used by Dr. Terzis. *Id.* at 7a-8a. Rush, however, again denied Moran's claim for reimbursement on the ground that Dr. Terzis's surgery was not medically necessary. *Id.* at 8a.

d. Moran then sought a state court order requiring Rush to reimburse her for the surgery. 00-1021 Pet. App. 8a, 36a. Rush again removed the action to district court, and the district court held that the removal now was appropriate. *Id.* at 36a-43a. The court held that Moran's suit to compel reimbursement for surgery was properly characterized as a claim for benefits under Section 502(a)(1)(B) of ERISA, and as such was completely preempted by the federal law. *Id.* at 41a-42a. Moreover, the court concluded that the state-law claim was not saved from preemption as an insurance regulation under Section 514(b)(2)(A) of ERISA, 29 U.S.C. 1144(b)(2)(A), because the Illinois HMO statute's IRO provision did not transfer or spread the policyholder's risk. 00-1021 Pet. App. 42a-43a.

On Rush's motion for summary judgment, the court concluded that Moran's only viable claim was a claim for benefits under the plan itself. 00-1021 Pet. App. 54a. The court concluded, however, that Rush did not abuse its discretion or act arbitrarily in denying Moran's benefit claim. *Id.* at 56a. The court noted that the plan granted Rush "the broadest possible discretion" in making benefit determinations, and also specified the method by which Rush would evaluate medical necessity determinations. *Ibid.* Because Rush used the specified evaluation method and relied on the opinions of three consulting physicians in making its determination, the court granted summary judgment to Rush. *Id.* at 56a-58a.

e. The Seventh Circuit reversed. The court agreed with the district court that Moran's claim was properly characterized as a claim for benefits under Section 502(a)(1)(B) and

therefore was properly removed to federal court. 00-1021 Pet. App. 13a.

Turning to Rush's preemption defense, the court adopted much of the reasoning set forth by the Secretary of Labor in an amicus brief in support of Moran. The court concluded that the state external review law "relates to" ERISA plans because it "has an effect on how benefit determinations are made." 00-1021 Pet. App. 16a. The court then determined, however, that the external review provision is a state law that "regulates insurance" and therefore falls within ERISA's insurance saving clause. *Id.* at 16a-17a. The court found that Section 4-10 satisfies the "common sense" test of insurance regulation because the independent review provision "is directed at the HMO industry as insurers." *Id.* at 17a. The court also stated that the "common sense" test is satisfied because the terms of the independent review provision "are substantive terms of all insurance policies in Illinois by operation of law," *ibid.*, and are therefore "'integral' to the insurer/insured relationship," *id.* at 18a (quoting *UNUM*, 526 U.S. at 374-375). The court reasoned that, because the independent review provision "changes the bargain between insurer and insured" and "is limited to entities within the insurance industry," it "satisfies the second and third *McCarran-Ferguson* factors." *Id.* at 18a (quoting *UNUM*, 526 U.S. at 374); see also *id.* at 16a (citing McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*). Citing this Court's decision in *UNUM*, see *id.* at 18a n.3, the court noted that it therefore need not decide whether the Illinois provision transfers or spreads risk—the third McCarran-Ferguson factor. *Ibid.*

The court next examined whether Section 4-10 is preempted as in conflict with Section 502(a) of ERISA, 29 U.S.C. 1132(a) (1994 & Supp. V 1999), under this Court's decision in *Pilot Life Insurance Co.* v. *Dedeaux*, *supra*. 00-1021 Pet. App. 19a. Although the court recognized that the Fifth Circuit reached a contrary conclusion in con-

sidering the "quite similar" provision of Texas Law in *Montemayor*, *ibid.*, the Seventh Circuit concluded that "§ 4-10 of the Illinois HMO Act cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." *Id.* at 21a. Instead, the court concluded that the independent review provisions of the Illinois HMO statute are incorporated into each participant's insurance contract, and accordingly a suit "to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." *Ibid.* Viewed in that light, the court continued, Section 502(a)(1)(B) remains the "sole launching ground" for enforcement of the state law provision, which simply "adds to the contract, by operation of law, an additional dispute resolving mechanism." *Id.* at 21a, 22a. Therefore, the court concluded that unlike the state common law doctrine of general applicability held preempted in *Pilot Life*, the independent review provision of the Illinois HMO Act imposes state-mandated insurance contract terms of the kind that were held in *UNUM* to be saved as insurance regulation. *Id.* at 23a.

The court circulated its decision to the full court for consideration of the desirability of rehearing en banc in light of the conflict between its decision and that of the Fifth Circuit in *Montemayor*. 00-1021 Pet. App. 23a n.7. Although the court declined to order rehearing en banc, Judge Posner, joined by three other judges, dissented from the denial of rehearing en banc. *Ibid.* In Judge Posner's view, "[t]he panel's decision creates a square conflict with" the Fifth Circuit's decision. *Id.* at 24a. He argued, *inter alia*, that the Illinois external review provision "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans." *Id.* at 25a. In his view, imposition of that scheme would improperly transform

the contractual suits envisioned by ERISA in Section 502(a)(1) into suits "for judicial review of the independent physician's decision." *Id.* at 26a.

DISCUSSION

At least thirty-seven states and the District of Columbia have enacted laws that require HMOs to provide some form of independent review of benefit denials. See 00-665 Pet. 27 n.24 (citing statutes). Those state laws vary considerably. The question whether they are preempted in light of ERISA's express preemption provision in Section 514, 29 U.S.C. 1144, and its exclusive provision for civil actions in Section 502(a), 29 U.S.C. 1132(a) (1994 & Supp. V 1999), is an important one. Moreover, the Fifth Circuit's decision in *Montemayor* holding that enforcement of the Texas independent review law is preempted conflicts with the Seventh Circuit's decision in *Rush Prudential* that a substantially similar Illinois law is not preempted and may be enforced.

Nonetheless, further review of the principal question presented by these cases at this time is not warranted. In the last Congress, the Senate and the House of Representatives each passed a bill that would have required, as a matter of federal law, that HMOs provide independent external review. Although no bill on the subject was ultimately enacted into law, new bills have been introduced on the subject in the current Congress, and the President has recently endorsed one of them. Each of the primary bills now under consideration would require, as a matter of federal law, that HMOs provide independent external review, although other aspects of the external review provisions in each of the bills (including the extent to which they would supersede state law) vary. If either of those bills becomes law, it would substantially limit the continuing importance of the issue presented by these cases. At this time, with Congress actively considering the various alternatives, it would be appropriate for this Court to defer to the possibility of a

comprehensive legislative resolution of the important social policy issues bound up in the principal question presented in these cases.

1. a. These cases present the question whether ERISA preempts the application of state statutes providing for independent, external review of decisions made by HMOs to deny medical coverage provided under ERISA plans. As petitioners in No. 00-665 point out, at least 37 States and the District of Columbia have enacted statutory provisions in recent years purporting to entitle their citizens to such review. The provisions vary substantially in a variety of respects. 00-665 Pet. 27 n.24. A review of the cited provisions indicates that most of them generally require the regulated entity to comply with the determination reached by the independent reviewer. A great many individuals obtain their HMO health coverage through ERISA plans. Accordingly, the question whether ERISA preempts state independent review statutes potentially affects the broad enforceability of those statutes, and it therefore is a question of substantial importance to many States and their citizens.

b. As Judge Posner recognized in his dissent from denial of rehearing en banc in *Rush Prudential*, the Seventh Circuit's decision in that case conflicts with the Fifth Circuit's decision in *Montemayor*. 00-1021 Pet. App. 25a.

The scope of the Texas and Illinois laws is in pertinent part identical. As explained by the Fifth Circuit, the Texas law "allow[s] a patient who has been denied coverage [by an HMO] to appeal to an outside organization," and it "requires" that the HMO "'comply' with the independent review organization's determination of medical necessity." 00-665 Pet. App. A13. The Illinois law in *Rush Prudential* "requires HMOs to submit to an independent physician review when there is a disagreement over whether a course of treatment is medically necessary," and if "the independent reviewer determines that the treatment is necessary, the

HMO is required under [the Illinois statute] to cover the treatment." 00-1021 Pet. App. 1a-2a.

Analyzing the two laws under ERISA, both courts of appeals concluded that they "relate to" ERISA plans within the meaning of ERISA's express preemption provision, 29 U.S.C. 1144(a). 00-665 Pet. App. A13 (Texas law is "squarely within the ambit of ERISA's preemptive reach."); 00-1021 Pet. App. 16a (Illinois law "squarely falls within ERISA's preemption clause."). Both courts of appeals also concluded that the state independent review laws "regulate[] insurance" and therefore fall within the scope of ERISA's insurance saving clause, 29 U.S.C. 1144(b)(2)(A). See 00-665 Pet. App. A15 (Texas law "meet[s] the common sense test of the saving clause" and "satisf[ies] the second and third prongs of the McCarran-Ferguson test."); 00-1021 Pet. App. 17a-18a (Illinois law "'regulates insurance' under a common sense understanding" and "satisfies the second and third *McCarran-Ferguson* factors."). At that point, however, the two courts parted company.

The Fifth Circuit in *Montemayor* held that, although the Texas law falls within the insurance saving clause, it nonetheless is preempted because it conflicts with Section 502(a) of ERISA, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). The court stated that the Texas law does not "create a cause of action for the denial of benefits." 00-665 Pet. App. A15. But the court held that it does "create[] an alternative mechanism through which plan members may seek benefits due them under the terms of the plan." *Ibid.* In the Fifth Circuit's view, this Court's decision in *Pilot Life* established that "the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan." *Ibid.* On that basis, the court concluded that "the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause." *Id.* at A16. See also *id.* at D6 (Texas law is "plainly a state regime for reviewing benefit decisions and

not a system for implementing a mandated term of insurance regulating a minimal standard of care.").

The Seventh Circuit, by contrast, held that the Illinois provision "cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." 00-1021 Pet. App. 21a. The court concluded that "[r]ather than providing an alternative remedy for Ms. Moran to recover benefits, [the Illinois law] simply establishes an additional internal mechanism for making decisions about medical necessity and identifies who will make that decision in those instances when the HMO and the patient's primary care physician cannot agree on the medical necessity of a course of treatment." *Id.* at 21a-22a. Therefore, "a suit by [Moran] to enforce the [statute's] provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." *Id.* at 21a.[2] Accordingly, while the Fifth Circuit had held the independent review provisions of the Texas statute preempted, the Seventh Circuit held that the Illinois statute is enforceable.[3]

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[2] To be sure, the *Rush Prudential* case involves a claim by a plan beneficiary for reimbursement of medical expenses after they had been incurred, while *Montemayor* involves a pre-enforcement challenge by insurers to a Texas state law that applies only to ex ante claims for the provision of medical services that the HMO has denied and not claims for reimbursement for services already provided outside the HMO. See 00-665 Pet. 4 n.4. But the Seventh Circuit did not rely on the fact that the case before it involved a claim for reimbursement, rather than for the provision of medical care, and the conclusion that the Illinois statute is not preempted as applied to an ex ante claim for medical services would appear to follow *a fortiori* from the Seventh Circuit's conclusion that the Illinois law is not preempted as applied to an ex post claim for reimbursement. Accordingly, it seems clear under the Seventh Circuit's decision that the Illinois statute is enforceable in the circumstances in which the Texas statute was held by the Fifth Circuit to be unenforceable.

[3] Although it comes to the Court in a somewhat different procedural posture, we see no reason that *Rush Prudential* would provide a better vehicle than *Montemayor* if this Court were to grant review. Petitioners in *Rush Prudential* intimate that because that case arose in the factual setting of a suit by a participant, it presents a more appropriate case for review than *Montemayor*, which involves a facial challenge to the state law. 00-1021 Pet. 20 & n.12. On the other hand, the Texas scheme at issue in *Montemayor* is embodied in a more detailed statutory scheme, which could aid this Court's review. At bottom, "the issue is one of law" in both cases that does not turn on factual distinctions. 00-1021 Pet. App. 24a (Posner, J., dissenting from the denial of hearing en banc).

2. Although there is a two-circuit conflict with respect to the preemption under the current ERISA provisions of mandatory independent review provisions, this Court need not—and in our view should not—grant further review in either case. Primarily, that is because Congress is actively considering legislation that would limit the ongoing importance of the question presented because it would, if enacted, substantially affect the scope of independent review of HMO decisions under ERISA plans and the scope of permissible state-law involvement in that subject. Questions regarding independent review of HMO decisions present serious issues of social and medical policy. Those issues should, if possible, be debated and decided in a legislative—not judicial—forum. Because Congress is currently engaged in precisely that debate, this Court should not grant certiorari to consider the question presented at this time.

a. In the 106th Congress, the House of Representatives and the Senate each passed a version of the so-called "patients' bill of rights" legislation. The Senate bill included a new federal mandate that a group health plan generally must "permit a participant or beneficiary * * * access to an independent external review with respect to an adverse coverage determination concerning a particular item or service" if the coverage was denied as not medically necessary and certain other conditions are satisfied. S. 1344, 106th Cong., 1st Sess. § 121(a) (1999) (adding new Section 503(e) to ERISA); see 145 Cong. Rec. S8623 (daily ed. July 15, 1999).

State laws that address independent review of HMO decisions would have generally continued to be analyzed for preemption under ERISA's preemption provision and its substantive provisions. The House bill similarly included a federal mandate that a group health plan or health insurance plan must "provide for an external appeals process" of any coverage decision that "involves a medical judgment." H.R. 2990, 106th Cong., 1st Sess. § 1103(a)(1) and (2)(A)(ii) (1999); see 145 Cong. Rec. H9523 (daily ed. Oct. 7, 1999). State independent review laws would have been preempted if they either failed to satisfy ERISA Section 514 or if they "prevent[ed] the application of a requirement of [ERISA]." See H.R. 2990, *supra*, § 1152(a)(1) and (2).

b. This year, two major bills have been introduced in Congress that would again address independent review of HMO decisions. S. 889, 107th Cong., 1st Sess. (2001), introduced by Senators Frist, Breaux, and Jeffords, would provide generally that HMOs and other health carriers "shall provide * * * participants and beneficiaries * * * with access to an independent external review for any denial of a claim for benefits" that satisfies certain conditions. *Id.* § 131(a) (adding new Section 503B(a) to ERISA). The bill specifies the independent review procedure in some detail, and it further specifies that the States "may provide for the designation or selection of qualified external review entities." *Ibid.* (adding new Section 503B(h)(1)(B)). Otherwise, the bill provides that "[n]othing in this [portion of the bill] shall be construed to affect or modify the provisions of section 514 of [ERISA] with respect to group health plans." *Id.* § 151(a)(2). The President has recently stated that he supports S. 889. See White House Office of Communications, Statement by the President, 2001 WL 513452 (May 15, 2001).

S. 283, introduced by Senator McCain and 13 other Senators, provides that an HMO "shall provide * * * participants, beneficiaries, and enrollees * * * with access to an independent external review for any denial of a claim for

benefits" that satisfies certain conditions. S. 283, 107th Cong., 1st Sess. § 104(a) (2001). It also specifies in some detail the procedures that would have to be employed in providing the independent review. S. 283 contains a number of preemption provisions that address the continuing effect of state law, § 152, including a provision that state independent review laws would generally remain applicable so long as they did not "prevent the application" of the federal provisions, § 152(b).

c. The two major bills introduced during the current Congress, like the ones that the Senate and the House of Representatives passed during the last Congress, would each institute a new federal mandate for HMOs to submit to independent external review of decisions based on medical necessity. They would therefore address the subject matter of the Texas and Illinois statutes at issue in *Montemayor* and *Rush Prudential*.

There are, of course, significant differences in the bills, including differences in the scope of independent review, the incidents of that federally mandated review, and the remaining scope permitted for state laws in the area. Since each of the bills is comprehensive legislation, each also contains numerous and varying other provisions addressing HMOs and other subjects. But the bills suggest that with respect to external review, there is a significant consensus that some form of federally mandated external review is desirable. Thus, insofar as the underlying question in this case is whether HMOs in Texas or Illinois must provide binding independent external review of their decisions, legislation actively being considered by Congress at this time would both address that question on a nationwide basis and substantially alter the nature and analysis of whatever preemption issues may remain in this area.

In *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), this Court addressed a comparably far-reaching claim that called into question the incentive systems that HMOs may utilize. The

Court noted that the claim turned on "judgment[s] about socially acceptable medical risk," which "would * * * necessarily turn on facts to which courts would probably not have ready access." *Id.* at 221. The Court noted that "a debatable social judgment [is] not wisely required of courts unless for some reason resort cannot be had to the legislative process," with its "preferable forum for comprehensive investigations and judgments of social value, such as optimum treatment levels and health-care expenditure." *Ibid.* Such resort to the legislative forum is now occurring with respect to the question of how to design a suitable structure of independent review of HMO health-care decisionmaking. Accordingly, it would be appropriate for this Court to defer review of the principal question presented in these cases until Congress has had the chance to produce a legislative resolution of the important social policy issues at stake.

d. Finally, a number of other factors suggest that review of the principal question presented in these cases may be deferred at the present time while Congress considers pending legislative proposals.

First, although 37 States and the District of Columbia have enacted independent review laws, the two cases here are, to our knowledge, the only cases to date in which the issue of ERISA preemption has been litigated. That suggests that resolution of the question of whether and to what extent such laws are preempted is not at this point so urgent from a nationwide perspective that it requires immediate resolution by this Court. Moreover, although the Fifth Circuit has held that ERISA preempts state laws that require HMOs that furnish health care to ERISA plan members to provide for independent review and has specifically invalidated the relevant provisions of Texas law, nothing in the Fifth Circuit's decision or in its interpretation of ERISA bars HMOs from choosing to provide such review, either as provided by state law or according to other standards, in order to attract new members, provide assurance to their

existing members, and perhaps furnish some protection against liability. The Fifth Circuit's decision therefore will not necessarily have the effect of eliminating all forms of independent external review for ERISA participants and beneficiaries, even in Texas or other States in that circuit.

Second, if Congress fails to enact a law addressing the subject of independent review in the near future and if the application of state laws addressing the subject proves to be problematic for the covered entities, the prevalence of state laws in the area will provide an opportunity for the preemption issue to be litigated afresh, and this Court therefore would likely have an opportunity to address the conflict in the circuits in the future. On the other hand, if Congress does enact independent review legislation, the nature of the preemption questions raised by state laws on the subject is likely to change dramatically.[4]

Third, the Fifth Circuit in *Montemayor* addressed the State's claim that this Court's decision in *Pegram*—which held that mixed medical-eligibility decisions made by HMO physicians are not fiduciary decisions under ERISA—"cast doubt" on the court's conclusion that the Texas independent review provision is preempted. 00-665 Pet. App. D2. The court stated that it did "not read *Pegram* to entail that every

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[4] If review were granted, the Court might also find it necessary to address questions concerning the relationship between the ERISA insurance saving clause, 29 U.S.C. 1144(b)(2)(A), and the scope of preemption required by ERISA's exclusive remedy provision, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). See *Pilot Life Ins. Co.* v. *Dedeaux*, *supra*; *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 376 n.7 (1999). That issue may have far-reaching consequences, since it may affect the enforceability of many state insurance regulations (including perhaps even those that provide for liability for insurers) insofar as they apply to insured ERISA plans. Those far-reaching implications suggest that this Court ought not address that issue in a case in which the crucial issue—the availability of independent review to those covered by HMOs—may be resolved on wholly different grounds by Congress.

conceivable state law survives preemption so long as it is based on a mixed question of eligibility and treatment." *Id.* at D2-D3. The Seventh Circuit in *Rush Prudential* did not discuss any analogous argument, perhaps because *Pegram* was decided after the case was briefed. Nonetheless, the *Pegram* argument rejected by the Fifth Circuit would likely be advanced in this Court if further review were granted in either of these cases. See 00-665 Pet. 24-27. The Court would then perhaps find it necessary to address that question, since it goes to the logically antecedent question whether the state law "relates to" ERISA plans, and therefore is within the scope of ERISA's preemption provision at all, regardless of the application of ERISA's insurance saving clause.

In the relatively short time since this Court decided *Pegram*, the federal courts of appeals and state courts have had little opportunity to address the question of what effect, if any, *Pegram*'s discussion of ERISA's fiduciary responsibilities has on ERISA preemption analysis, especially in the context of independent review statutes.[5] The answer to that question could be of very broad significance.[6] If this Court defers review of the principal question presented in

[5] See *Pappas* v. *Asbel*, 768 A.2d 1089 (Pa. 2001) (*Pegram* requires conclusion that ERISA does not preempt state negligence claim against HMO whose physician refused to permit referral to non-network hospital); *Pryzbowski* v. *U.S. Healthcare*, 245 F.3d 266 (3d Cir. 2001) (relying in part on *Pegram* to conclude that state-law claim against HMO for injuries from delays in approving referrals completely preempted).

[6] If this Court's analysis in *Pegram* leads to the conclusion that ERISA does not preempt state laws concerning medical necessity decisions made by managed care entities in the context of ERISA plans, then that conclusion would apparently apply to self-funded as well as insured plans. It could also have implications for the scope of permissible state-law suits against HMOs arising out of such medical necessity decisions. In those respects, the question concerning the effect, if any, of *Pegram* on ERISA preemption analysis could have very broad implications.

these cases, it will enable the lower federal courts and state courts to explore the connection between *Pegram* and ERISA preemption analysis more thoroughly in the first instance. Insofar as this Court finds it necessary to address that issue in a future case, it would then have the benefit of a fuller development of the issue in the lower federal and state courts.[7]

4. The Fifth Circuit also held that the Texas independent review provisions are preempted "under general conflict principles" insofar as they apply to FEHBA plans. Regulations of the Office of Personnel Management (OPM) establish a detailed administrative procedure for review by OPM of denials of benefits by FEHBA plans, 5 C.F.R. 890.105-890.106, followed by review of OPM's decision under the Administrative Procedure Act, 5 U.S.C. 701 *et seq.*, in federal court. See 5 C.F.R. 890.107. State laws (even those regulating insurance, see 5 U.S.C. 8902(m)(1) (1994 & Supp. V 1999))[8] may neither add to the benefits provided under

[7] Respondents in *Montemayor* argue that review is not warranted because "[t]he effect of [new claims processing regulations promulgated by the Department of Labor] on the issue of ERISA's preemption of state external review laws has yet to be evaluated by any lower federal court." 00-665 Br. in Opp. 25. The new regulations, however, provide that "[n]othing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section," 29 C.F.R. 2560.503-1(k)(1), and specifically provide that state external review procedures do not "prevent the application of" any federal requirements. See 29 C.F.R. 2560.503-1(k)(2) ("[A] State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.").

[8] FEHBA's preemption provision states that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent

FEHBA plans nor supplement the federal administrative remedy. The Seventh Circuit did not address any FEHBA preemption question, nor has that question been addressed by any other court of appeals. Petitioners in *Montemayor* present little discussion or analysis of the FEHBA issues in the case. See 00-665 Pet. 27 n.23 (noting simply that "FEHBA preemption * * * entails a 'relates to' analysis"). Accordingly, further review of the Fifth Circuit's determination that the Texas independent review provisions are preempted by FEHBA is not warranted.

CONCLUSION

The petitions for writs of certiorari should be denied.

Respectfully submitted.

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of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law * * * *which relates to health insurance or plans* * * * to the extent that such law or regulation is inconsistent with such contractual provisions." 5 U.S.C. 8902(m)(1) (1994 & Supp. V 1999) (emphasis added).